



## TEXAS DEPARTMENT OF INSURANCE

### Division of Workers' Compensation - Medical Fee Dispute Resolution (MS-48)

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## MEDICAL FEE DISPUTE RESOLUTION FINDINGS AND DECISION

### GENERAL INFORMATION

**Requestor Name**

Ramesh Shah, M.D.

**Respondent Name**

Texas Mutual Insurance Company

**MFDR Tracking Number**

M4-15-4175-01

**Carrier's Austin Representative**

Box Number 54

**MFDR Date Received**

August 26, 2015

### REQUESTOR'S POSITION SUMMARY

**Requestor's Position Summary:** "... the payment issued to us does not meet the recommended allowance as set by the Texas Medical Fee Guidelines for the procedures billed."

**Amount in Dispute:** \$850.00

### RESPONDENT'S POSITION SUMMARY

**Respondent's Position Summary:** "The requestor provided DESIGNATED DOCTOR services then billed Texas Mutual codes 99456-W5/NM and 99456-W8/RE. The date of the bill and the DWC69 is 5/5/15. The date of the narrative report is 5/12/15. The DWC69 is signed but not dated as required by Rule 130.1(d).

For these reasons no payment is due."

**Response Submitted by:** Texas Mutual Insurance Company

### SUMMARY OF FINDINGS

Dates of Service	Disputed Services	Amount In Dispute	Amount Due
May 5, 2015	Designated Doctor Examination	\$850.00	\$0.00

### FINDINGS AND DECISION

This medical fee dispute is decided pursuant to Texas Labor Code §413.031 and applicable rules of the Texas Department of Insurance, Division of Workers' Compensation.

**Background**

- 28 Texas Administrative Code §133.307 sets out the procedures for resolving medical fee disputes.
- 28 Texas Administrative Code §134.204 sets out the guidelines for billing and reimbursing Division-specific services.
- The insurance carrier reduced payment for the disputed services with the following claim adjustment codes:
  - CAC-P12 – Workers' Compensation jurisdictional fee schedule adjustment.

- CAC-16 – Claim/service lacks information or has submission/billing error(s) which is needed for adjudication.
- 225 – The submitted documentation does not support the service being billed. We will re-evaluate this upon receipt of clarifying information.
- 892 – Denied in accordance with DWC rules and/or medical fee guideline including current CPT code descriptions/instructions.
- CAC-193 – Original payment decision is being maintained. Upon review, it was determined that this claim was processed properly.
- 724 – No additional payment after a reconsideration of services.
- Notes: "DATE OF EXAM ON DWC 69 AND REPORT DON'T MATCH."

### **Issues**

Are the insurance carrier's reasons for denial or reduction of payment supported?

### **Findings**

The insurance carrier denied disputed services with claim adjustment reason code 225 – "THE SUBMITTED DOCUMENTATION DOES NOT SUPPORT THE SERVICE BEING BILLED..." The insurance carrier noted on the reconsideration explanation of benefits, "DATE OF EXAM ON DWC 69 AND REPORT DON'T MATCH."

28 Texas Administrative Code §134.204 (j)(1) states,

The total MAR for an MMI/IR examination shall be equal to the MMI evaluation reimbursement plus the reimbursement for the body area(s) evaluated for the assignment of an IR. The MMI/IR examination shall include:

- (A) the examination;
- (B) consultation with the injured employee;
- (C) review of the records and films;
- (D) the preparation and submission of reports (including the narrative report, and responding to the need for further clarification, explanation, or reconsideration), calculation tables, figures, and worksheets; and,
- (E) tests used to assign the IR, as outlined in the AMA Guides to the Evaluation of Permanent Impairment (AMA Guides), as stated in the Act and Division rules in Chapter 130 of this title (relating to Impairment and Supplemental Income Benefits).

Further, 28 Texas Administrative Code §134.204 (k) states,

The following shall apply to Return to Work (RTW) and/or Evaluation of Medical Care (EMC) Examinations. When conducting a Division or insurance carrier requested RTW/EMC examination, the examining doctor shall bill and be reimbursed using CPT Code 99456 with modifier "RE." In either instance of whether MMI/IR is performed or not, the reimbursement shall be \$500 in accordance with subsection (i) of this section and shall include Division-required reports. Testing that is required shall be billed using the appropriate CPT codes and reimbursed in addition to the examination fee.

Review of the submitted information finds that the examination/consultation narrative does not support the date of service billed. The insurance carrier's denial reason is supported. Additional reimbursement cannot be recommended.

### **Conclusion**

For the reasons stated above, the Division finds that the requestor has not established that additional reimbursement is due. As a result, the amount ordered is \$0.00.

## ORDER

Based upon the documentation submitted by the parties and in accordance with the provisions of Texas Labor Code §413.031, the Division has determined that the requestor is entitled to \$0.00 reimbursement for the disputed services.

### Authorized Signature

_____	Laurie Garnes	September 17, 2015
Signature	Medical Fee Dispute Resolution Officer	Date

### YOUR RIGHT TO APPEAL

Either party to this medical fee dispute has a right to seek review of this decision in accordance with 28 Texas Administrative Code §133.307, 37 *Texas Register* 3833, applicable to disputes filed on or after June 1, 2012.

A party seeking review must submit a **Request to Schedule a Benefit Review Conference to Appeal a Medical Fee Dispute Decision** (form **DWC045M**) in accordance with the instructions on the form. The request must be received by the Division within **twenty** days of your receipt of this decision. The request may be faxed, mailed or personally delivered to the Division using the contact information listed on the form or to the field office handling the claim.

The party seeking review of the MFDR decision shall deliver a copy of the request to all other parties involved in the dispute at the same time the request is filed with the Division. **Please include a copy of the *Medical Fee Dispute Resolution Findings and Decision*** together with any other required information specified in 28 Texas Administrative Code §141.1(d).

**Si prefiere hablar con una persona en español acerca de ésta correspondencia, favor de llamar a 512-804-4812.**